Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 24, 2019	2019_593573_0011	000070-19, 003095-19	Critical Incident System

Licensee/Titulaire de permis

Deep River and District Hospital
117 Banting Drive DEEP RIVER ON K0J 1P0

Long-Term Care Home/Foyer de soins de longue durée

The Four Seasons Lodge
117 Banting Drive DEEP RIVER ON K0J 1P0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 10, 11, 12, 15, 16, 17 and 18, 2019.

The Critical Incident System (CIS) Log #003095-19 - related to allegation of improper/ incompetent treatment/ care of a resident that results in harm or risk to a resident was inspected during this inspection.

Follow up log #000070-19 CO #001 from Inspection 2018_593573_0018 related to Duty to protect s. 19. (1) Compliance due date March 20, 2019 was conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation Therapist (RT), Food Service Workers (FSW), Housekeeping Staff, Personal Support Workers (PSW) and staffing clerk.

During the course of the inspection, Inspector reviewed critical incident reports, licensee's internal investigation documentation, as applicable, licensee's "Abuse and Neglect - Zero Tolerance and Mandatory Reporting" policy, residents' health care record, staff training materials and attendance records.

In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_593573_0018	573

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #573 reviewed the licensee's policy titled Abuse and Neglect - Zero Tolerance and Mandatory Reporting, dated July 2017, Review Date May 15, 2018. The policy indicated that : " Any employee, medical staff or board member who is aware of or suspect any of the following must report it as soon as possible in accordance with the reporting procedure of the home: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident."

The licensee submitted a Critical Incident Report (CIR) on a specified date to the Ministry of Health and Long -Term Care (MOHLTC) related to allegations of improper/ incompetent treatment or care of resident #001 that resulted in harm or risk to the resident. The CIR indicated that resident #001 was transferred poorly by an RPN against their wish.

During an interview with Inspector #573 on April 17, 2019, PSW #112 indicated that on a specified date, they observed resident #001 was transferred poorly by RPN #113. Further, the PSW indicated that RPN #113 transferred resident #001 from bed against their wish. PSW #112 indicated to Inspector #573 that they did not report this incident to their supervisor immediately. PSW #112 indicated awareness that the incident should have been reported right away to their supervisor or the MOHLTC.

On April 17, 2019, Inspector #573 spoke with the Director of Care (DOC), who indicated that three days after the incident, PSW #112 reported allegation of RPN #113 to resident #001 improper/ incompetent treatment or care that resulted in risk to the resident. The DOC indicated to the inspector that an investigation was initiated immediately and the investigation concluded that the allegations were unfounded. Furthermore, the DOC indicated that PSW #112 did not immediately report the allegations of improper/ incompetent care of resident #001 as per the licensee's Abuse and Neglect - Zero Tolerance and Mandatory Reporting policy. (Log #003095-19) [s. 20. (1)]

Issued on this 4th day of June, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.